PROVINCE OF MANITOBA

REGULATIONS

under the

Hospital Services Insurance Act

Filed June 24, 1958

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MANITOBA REGULATION 41/58

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A Regulation under The Hospital Services Insurance Act

[Filed June 24th, 1958]

INTERPRETATION

1. In this regulation:

(a) "Act" means The Hospital Services Insurance Act;

(b) "appropriate agent" means the agent to whom a person is required to pay his premiums;

(c) "change in status" means the circumstance of a single person or a dependant becoming a family head or a family head becoming a single person, or any other change by reason of which the premium payable by any person ceases to be payable or is payable in a different amount;

(d) "family head" means a person who is liable for the payment of a premium on behalf of one or more resident dependants;

(e) "members of the Royal Canadian Mounted Police Force" means the members of that Force and includes persons appointed as Special constables by the Commissioner of the Royal Canadian Mounted Police and designated by him as being eligible to receive hospital care and treatment from the Force.

(f) "pay period" means

(i) in respect of employees, that six month period, and

(ii) in respect of persons other than employees, that two month period

that terminates at the end of the second month next preceding the beginning of each benefit period other than the initial benefit period;

(g) "single person" means a person who has no dependants and who is liable for the payment of a premium only for himself;

(h) "unorganized area" means all those parts of unorganized territory that are not included in a local government district;

(i) "waiting period" means that one month period to which reference is made in subsection (2) of section 8.

INSURED SERVICES

2. (1) For the purposes of the Act and this regulation the following services are in-patient services:

(a) Accommodation and meals such as are supplied to standard ward patients.

(b) Necessary nursing service.

(c) Laboratory, radiological, and other diagnostic procedures together with the necessary interpretations for the purpose of maintaining health, preventing disease, and assisting in the diagnosis and treatment of any injury, illness, or disability.

(d) Drugs, biologicals, and related preparations when administered in a hospital as may be provided in an agreement.

(e) Use of an operating room, case room, and anaesthetic facilities, including necessary equipment and supplies.

(f) Routine surgical supplies.

(g) Use of radiotherapy facilities where available.

(h) Use of physiotherapy facilities where available.

(i) Services rendered by persons who receive remuneration therefor from the hospital.

(j) Such other services as are specified in an agreement.

(2) For the purposes of the Act and this regulation, all of the following services provided to an out-patient by a hospital when used for emergency diagnosis and treatment within 24 hours after an accident are out-patient services:

(a) The use of an operating room and anaesthetic facilities including the necessary equipment and supplies.

(b) Routine surgical supplies.

(c) Necessary nursing services.

(d) Drugs, biologicals and related preparations when administered in a hospital as may be provided in an agreement.

(e) Meals such as are supplied to standard ward patients.

(f) Laboratory, radiological and other diagnostic procedures, together with the necessary interpretations for the purpose of assisting in emergency diagnosis and treatment.

(3) The following services are not included in insured services:

(a) Admission chest X-rays.

(b) Syphilis serology.

REGISTRATION

3. On and after the 1st day of June, 1958, persons who are liable for the payment of a premium and who are not already registered shall, notwithstanding the provisions of Manitoba Regulation 25/58, register with the appropriate agent.

EXEMPT EMPLOYEES

4. For the purposes of this regulation and of subsection (1) of section 12 of the Act the following are not employees;

(a) Persons whose income from an employer is less than $85.00 a month.

(b) Persons whose term of employment is less than 100 hours in any month unless the employer makes an instalment remittance for that person.

(c) Persons who are employed for a temporary period and the date of the termination of whose employment is determined at the commencement of the employment and is shown on the records of the employer to be a date that is before the first day of the third month following the date of the beginning of the employment.

(d) Persons attending any institution of learning who are on vacation and whose term of employment does not exceed five months.

(e) Persons who are members of Special Group D.

SPECIAL GROUPS

5. (1) Persons coming within any one of the classes of persons mentioned in clauses (a) to (d) are members of the special group to which that clause applies:

(a) Employers are members of Special Group A.

(b) Persons other than those mentioned in clause (c) who are

(i) paid wages, salary or other remuneration out of the Consolidated Revenue fund (Canada), or

(ii) employed by Her Majesty in right of Canada, or by any agent of Her Majesty

and in respect of whom a regulation has been made by the Governor in Council pursuant to subsection (4) of section 5 of the Hospital Insurance and Diagnostic Services Act (Canada) are members of Special Group B.

(c) Members of the regular forces of the Canadian Forces and of the Royal Canadian Mounted Police Force who have one or more dependants residing in the province are members of Special Group C.

(d) Persons in receipt of a pension out of a fund or scheme that has been approved by the commissioner are members of Special Group D.

(2) The commissioner shall not approve a fund or scheme as provided in clause (d) of subsection (1) until he has completed an arrangement, in writing, with the operator of such fund or scheme under which the operator has undertaken to remit to the commissioner the premiums payable by 75 per centum of the residents who are in receipt of a pension out of that fund or scheme and who are not otherwise insured persons.

BENEFIT PERIOD

6. (1) A benefit period to which reference is made in the Act and this regulation is a period of six months computed from the first day of January and the first day of July in each year.

(2) The first benefit period commences on the first day of July, 1958 and shall be known as the "initial benefit period"; the next following benefit period shall be known as "benefit period No. 1"; and thereafter each successive benefit period shall be designated by number in numerical sequence.

PREMIUMS

7. The premiums payable in respect of each benefit period other than the initial benefit period are:

(a) For single persons,
$12.30 per benefit period,

(b) Subject to clause (c), for family heads,
$24.60 per benefit period,

(c) For members of Special Group C

(i) with only one dependant,
$12.30 per benefit period, and

(ii) with more than one dependant,
$18.60 per benefit period.

8. (1) All premiums are payable in advance and shall be paid in full, as hereinafter provided, on or before the end of the pay period next preceding the benefit period in respect of which they are paid.

(2) Except as otherwise provided in this regulation, where a person fails to comply with subsection (1), or where a person first becomes a resident, neither he nor his dependants, if any, are insured persons nor are they entitled to insured services until the expiration of a one month waiting period after the premium is paid.

9. (1) At the end of each month during a pay period, every employer shall remit to the commissioner an instalment of the premium payable by each of his employees in an amount that is equal to one-sixth of that employee's total premium for the next following benefit period.

(2) An employer who has not made an agreement with his employees or with a certified bargaining agent on their behalf providing for the payment by the employer of all or any part of the premiums payable by such employees shall deduct the amount of all instalments to be remitted on account of their premiums from the wages or salary payable to those employees.

10. Persons who are members of Special Group A shall remit their own premiums to the commissioner in the manner, and at the times, provided in section 9.

11. Persons who are members of Special Groups B and C and whose premiums are not remitted by Her Majesty in right of Canada or by an agent of Her Majesty shall pay their premiums in the manner, and at the times, prescribed in section 16.

12. Persons who are members of Special Group D shall pay their premiums through the operator of the fund or scheme at such times and in such manner as may be provided in the arrangement between the commissioner and the operator of such fund or scheme.

13. (1) Where a person ceases to be an employee during any pay period, his employer shall provide him with a "notice of change form" showing thereon the last month for which an instalment remittance has been made on behalf of the employee and the total of the instalments remitted for him during that pay period; and the notice shall be in such form, and contain such particulars, as the minister may prescribe.

(2) A person who so ceases to be an employee and who again becomes an empolyee during the same pay period, shall present his notice of change form to his new employer and the employer, with the first monthly remittance for that employee, shall remit to the commissioner such additional amount as will pay the total amount of all instalments for which the employee is in arrears.

(3) Where such a person does not again become an employee during the same pay period, he shall, on or before the day on which the pay period ends, present his notice of change form to the appropriate agent, and at the same time shall pay to that agent the balance of the premium payable by him.

14. Where a person who was not an employee at the beginning of a pay period becomes an employee during that pay period, his employer, when remitting that employee's first monthly instalment, shall remit to the commissioner such additional amount as will pay the total amount of all instalments for which the employee is in arrears as if he had been an employee from the beginning of the pay period.

15. Where, by reason of a change in status during a pay period, an employee becomes liable for payment of a higher premium for the next following benefit period, his employer shall remit such additional amount with the next following monthly instalment as, together with the instalments paid, will be equal to the amount that the employee would have been liable to pay if he had had such new status from the beginning of that pay period.

16. (1) On or before the last day of each pay period, persons whose premiums have not been paid or remitted pursuant to sections 9, 10, 11 or 12 shall pay the premiums for which they are liable in respect of the next following benefit period, or any unpaid balance of those premiums, to that one of the persons hereinafter designated that is appropriate:

(a) Persons residing in a municipality shall pay their premiums to the municipality.

(b) Persons residing in local government districts shall pay their premiums to the local government district.

(c) Persons residing in National or Provincial Parks or on similar Crown lands shall pay their premiums to the municipality or the local government district that is nearest to them.

(d) Persons residing in unorganized areas shall pay their premiums to the Minister of Municipal Affairs.

(2) Where by reason of a change in status during a pay period, a person who has paid his premiums pursuant to subsection (1) becomes liable for the payment

of a higher premium for the next following benefit period, he shall, forthwith, pay such increased amount to the appropriate agent.

17. (1) Where, during a benefit period, or during the month immediately preceding a benefit period, a person becomes a resident who is liable for the payment of a premium, he shall pay to the appropriate agent that part of the premium that is computed by dividing the premium by six and multiplying the result by the number of whole months remaining in that benefit period less one.

(2) One month after making the payment such a person and his dependants, if any, are insured persons entitled to insured services for the remainder of that benefit period.

18. (1) Where a person ceases to be

(a) A dependant, or

(b) An inmate of a penitentiary, or

(c) A member of

(i) any one of the classes of persons designated in clause (e) of subsection (1) of section 7 of the Act, or

(ii) the regular forces of the Canadian Forces or of the Royal Canadian Mounted Police Force with no resident dependants, or

(iii) Special Group C

and is a resident who is not otherwise an insured person, he shall, subject to subsection (2), pay to the appropriate agent that part of the premium payable by him for the current benefit period that is computed by dividing the premium by six and multiplying the result either by one or by the number of whole months remaining in that benefit period whichever is the larger; and the payment shall be made within one month after the person so ceases to be a dependant, an inmate, or a member of that class of persons referred to in clause (c).

(2) A person who has been a member of Special Group C

(i) with one dependant, or

(ii) with two or more dependants

shall pay only one-half or one-quarter respectively of the amount computed pursuant to subsection (1).

(3) Where payment is made as provided in subsections (1) and (2), the person and his dependants, if any, are insured persons for the remainder of that benefit period commencing from the day on which the payment is made.

(4) Where a person undergoes the change referred to in subsection (1) between the end of a pay period and the commencement of the next following benefit period, he shall pay his premium for the next following benefit period to the appropriate agent before the benefit period commences and where he does so he and his dependants, if any, are insured persons entitled to insured services for the whole of that benefit period without a waiting period.

19. Where, between the end of a pay period and the commencement of the next following benefit period, any person who has paid a premium has a change in status that increases the premium for which he is liable, he shall forthwith pay to the appropriate agent the full amount of the increase and his dependants are thereupon insured persons for that following benefit period without a waiting period.

20. A resident other than an employee, at any time during the pay period next preceding the beginning of a calendar year, may pay the premium payable by him in advance for the whole of that calendar year; and in that case the agent shall deliver to him the hospital services certificate for the next following benefit period, and shall deliver the hospital services certificate for the second following benefit period when he receives it from the commissioner.

RECIPROCAL BENEFITS

21. (1) An insured person who departs the province to take up residence in a participating province and who obtains an out of province certificate from the commissioner shall be deemed to be a resident of Manitoba during any waiting period not exceeding three months required of residents in that participating province.

(2) An insured person who departs the province to take up residence in a place that is not in a participating province and who obtains an out of province certificate from the commissioner shall be deemed to be a resident for a period of three months after his departure.

(3) Out of province certificates, in such form as the minister may prescribe, will be issued by the commissioner on application to him supported by such evidence as he may require and on payment of the appropriate part of the premium payable by the insured person, if any.

(4) A person named in an out of province certificate and his dependants, if any, continue to be insured persons entitled to insured services in the province and subject to the conditions of section 44 are entitled to reimbursement or payment as therein provided in respect of insured services received in hospitals outside the province until the certificate expires.

22. (1) Where a person who becomes a resident produces evidence that he is an insured person in, and entitled to receive insured services from a participating province and desires to avail himself of those benefits, the premium or premiums payable by him shall be reduced by the amount that is computed by dividing the premium by six and multiplying the result by the number of whole months during which he is entitled to insured services from the participating province from whence he came.

(2) On payment in accordance with subsection (1), such a person and his dependants, if any, become insured persons entitled to insured services commencing one month after the payment is made or on the day that they cease to be entitled to insured services from the participating province, whichever is the later.

23. (1) A person who has been a resident and who is the dependant of an insured person in Manitoba shall, while he continues to be such a dependant, be deemed to be a resident and where he obtains a dependant's out of province certificate in his name he is entitled, subject to the conditions of section 44, to reimbursement or payment as therein provided in respect of insured services received in hospitals outside the province until the certificate expires or he ceases to be a dependant whichever is the sooner.

(2) Dependant's out of province certificates, in such form as the minister may prescribe, will be issued by the commissioner on application to him supported by such evidence as he may require.

REMITTANCE TO COMMISSIONER

24. Employers shall remit all premium instalments in respect of each of their employees by the 5th of the month next following the month for which the instalment is remitted.

25. Agents other than employers shall remit all premium monies received within one week after receiving them.

26. (1) When remitting premiums to the commissioner, each employer and agent shall make a report thereon containing such information and in such form as the commissioner may prescribe.

(2) Employers and agents shall report forthwith to the commissioner the names and addresses of all single persons and family heads who fail to register or to pay the premiums payable by them.

REFUNDS

27. The commissioner, on the application of any person entitled to receive a refund of premiums and on evidence satisfactory to him, shall make the refund, or proportion thereof, as provided in section 29.

28. The application for a refund shall be in such form and shall contain such particulars as the minister may prescribe.

29. The amount of the refunds payable under section 27 shall be computed as follows:

(a) On the death of an insured person, by dividing the premium paid or the part thereof that is applicable to the deceased alone, by six and multiplying the result by the number of whole months remaining in the benefit period after the date of death.

(b) On the applicant ceasing to be a resident of the province, by dividing the premium paid by six and multiplying the result by the number of whole months remaining in the benefit period after the date of ceasing to be a resident.

(c) On the applicant ceasing to be a family head, by dividing the premium paid by him as a family head in respect of the benefit period next following the benefit period during which the applicant ceased to be a family head, by two.

30. (1) Where, in any case, the minister is of the opinion that it is just and equitable to refund the whole or any part of an unearned premium, he may direct the commissioner, in writing, to make the refund.

(2) On receiving such a direction, the commissioner, in respect of the appropriate benefit period, shall refund that part of the premium or portion thereof that is applicable, that is computed by dividing the premium paid or the applicable portion thereof by six and multiplying the result by the number of whole months remaining in that benefit period subsequent to such date as may be specified in the minister's direction.

RECIPIENTS OF PUBLIC ASSISTANCE AND THE LIKE

31. (1) The commissioner shall issue without charge a hospital services certificate to every person who is not otherwise an insured person and who is a member of any of the classes of persons designated in clause (e) of subsection (1) of section 7 of the Act.

(2) Where any person to whom subsection (1) applies is unable to manage his own affairs the commissioner shall deliver the certificate to that person's legal representative.

(3) When a person ceases to be a member of any class of persons to which subsection (1) applies

(a) the proper authority shall forthwith notify the commissioner of that fact, and

(b) any hospital services certificate issued to him or to his legal representative pursuant to subsections (1) and (2) expires and he shall forthwith return the certificate to the commissioner.

HOSPITAL SERVICES CERTIFICATES

32. (1) Hospital services certificates, in such form as the minister may prescribe, shall be issued to insured persons who are family heads or single persons as follows:

(a) In respect of the initial benefit period, by registrars, at the time of registration.

(b) In respect of all subsequent benefit periods, by the agent receiving or remitting the premiums, at the time the premium is paid.

(2) Employers shall not issue a hospital services certificate to an employee in respect of any benefit period until the full amount of that employee's premium for that benefit period has been remitted.

33. (1) Subject to subsection (3) of section 31, hospital services certificates expire at the end of the benefit period in respect of which they are issued or on the day that the insured persons covered therein cease to be residents, whichever is the sooner.

(2) Registrars and agents shall retain their copy of all hospital services certificates issued by them for a period of one year after the issue thereof.

RETURN OF HOSPITAL SERVICES CERTIFICATES

34. On the death of an insured person who is either a single person or a family head, his legal representative shall

(a) in the case of a single person, return forthwith to the commissioner the hospital services certificate issued to the deceased person; and

(b) in the case of a family head, forthwith notify the commissioner of that fact, giving the time and place of death together with the number of the hospital services certificate issued to the deceased person.

HOSPITAL ADMISSIONS AND LENGTH OF STAY

35. (1) An insured person is entitled to receive insured services in a hospital without paying any charge to the hospital for the insured services if

(a) he has been admitted as an in-patient to the hospital on the order of a duly qualified medical practitioner; or

(b) subject to section 41, he has been admitted as an in-patient to the hospital on the order of a person who is duly registered under The Dental Association Act for the current year; or

(c) he has been received in the hospital and examined as an out-patient by a duly qualified medical practitioner and treated as an out-patient, if necessary.

(2) In the case of an emergency, no hospital with available accommodation in private or semi-private wards may refuse to admit an insured person because there is no standard ward accommodation available.

(3) When a hospital provides an insured person with accommodation in a private or semi-private ward because the patient is

(a) an emergency admission and no standard ward beds are available in that hospital; or

(b) an isolation case; or

(c) in such condition that he requires that type of accommodation;

and accommodation in the private or semi-private ward was not requested by or on behalf of the patient, the hospital shall not make any charge to the patient for that accommodation.

36. No duly qualified medical practitioner or person registered under The Dental Association Act shall authorize or order an in-patient admission to a hospital if, having regard for the condition of the patient, the diagnosis, treatment or care required, can be provided as an out-patient service.

37. (1) An insured person shall be entitled to insured services only for the period of time following admission during which the insured services are medically required.

(2) To determine the period of time during which an insured person has need of insured services, the commissioner may require a hospital to secure from the

patient's attending physician and forward to the commissioner a written statement regarding the patient's condition and the reason or necessity for the patient receiving insured services or other treatment during all or any portion of his stay in hospital.

38. (1) No duly qualified medical practitioner shall admit or order to be admitted, to a hospital any patient unless he is of the opinion that it is medically necessary for the patient to be admitted to hospital as an in-patient.

(2) No person who is registered under The Dental Association Act shall admit, or order to be admitted, to a hospital any patient unless he is satisfied that the patient qualifies under the conditions prescribed in section 41, and he is of the opinion that it is necessary for the patient to be admitted to hospital as an in-patient.

39. (1) As soon as the attending physician is of the opinion that an insured person under his care no longer requires active hospital care and treatment, the physician shall order the patient to be discharged from the hospital forthwith.

(2) The commissioner shall cease to make payment for a patient to a hospital on making the payment for the day preceding the day on which the attending physician orders the patient to be discharged under subsection (1).

(3) Subsections (1) and (2) also apply to insured persons admitted by, or on the order of, a person registered under The Dental Association Act; but insured services for such a patient shall not be continued for more than two days without a further admission order by a duly qualified medical practitioner.

40. (1) When, in the opinion of the commissioner, a doubt exists concerning the necessity for in-patient services in a specific case, the commissioner may direct the director of standards appointed under The Hospitals Act to investigate and report on the case.

(2) If, in the opinion of the commissioner, after consideration of the report of the director of standards, insured services are no longer required, the patient shall not be entitled to further insured services in respect of the illness under review

ADMISSION BY DENTISTS

41. Persons who are duly registered under The Dental Association Act for the current year may authorize the admission to a hospital of an insured person as an in-patient only where admission is required under any one or more of the following conditions:

(a) The removal of eight or more permanent teeth.

(b) The removal of an impacted tooth or teeth.

(c) The removal of any teeth where the removal is required by reason of a systemic condition.

PAYMENTS TO MANITOBA HOSPITALS

42. (1) The commissioner, commencing with the initial benefit period, shall make the following payments to each hospital in Manitoba that is licensed under The Hospitals Act:

(a) A semi-monthly payment computed by subtracting

(i) the product obtained by multiplying the hospital's estimated number of patient days for insured persons, during the year, by two dollars;

from

(ii) the amount of the hospital's budget for insured services to insured persons, approved under subsection (6) of section 21 of the Act;

and dividing the result by twenty-four.

(b) Periodic payments in respect of each month, computed by multiplying

the actual number of patient days of care for insured persons for which accounts have been received and approved by the commissioner during that month by two dollars.

(c) A monthly payment, computed by dividing the hospital's budget of costs other than insured services, that has been approved pursuant to subsection (6) of section 21 of the Act, by twelve.

(2) During the initial benefit period the payments provided for in clauses (a) and (c) of subsection (1) shall be computed only in respect of the last six months of the year 1958 and the divisor shall be twelve and six respectively.

(3) That portion of all payments made pursuant to clause (a) of subsection (1) that is attributable to depreciation on equipment and all payments made pursuant to clause (c) of subsection (1) shall be funded by the hospital and expended only for such purposes as the minister may approve.

43. (1) At the end of each year every hospital licensed under The Hospitals Act shall submit its financial statement for that year to the commissioner who shall refer it, for consideration, to The Hospital Budget Committee.

(2) The financial statement may include depreciation on furniture and equipment; but where any item of equipment is purchased after July 1st, 1958, at a cost in excess of one thousand dollars, depreciation thereon may be included only if the commissioner has approved the purchase.

(3) The committee shall examine the financial statement and recommend to the minister the total amount that the hospital is entitled to receive in respect of insured services that have been received therein by insured persons during that year; but before sending its recommendation to the minister, the committee shall notify the hospital of its recommendation and give the hospital an opportunity of requesting changes therein and of being heard with respect thereto.

(4) Where the hospital does not request the making of changes or, after considering the changes requested, the committee makes a decision with respect thereto, the committee shall forward its recommendation to the minister and, at the same time, notify the hospital that it has done so.

(5) Where the hospital is dissatisfied with the recommendation of the committee, it may, within seven days after receiving the notice under subsection (3), notify the minister in writing that it desires to be heard with respect thereto.

(6) On the expiration of the time for giving notice under subsection (5) or, if notice has been given, on hearing the hospital the minister may make his recommendation to the Lieutenant-Governor-in-Council with respect thereto; and the Lieutenant-Governor-in-Council may approve the amount recommended or such other amount as he may see fit.

(7) The amount so approved by the Lieutenant-Governor-in-Council shall be the determined amount to which reference is made in subsection (7) of section 21 of the Act.

OUT OF PROVINCE PAYMENTS

44. (1) Subject to subsections (2), (3), (4) and (5) the commissioner may

(a) reimburse an insured person who receives treatment in a hospital outside Manitoba for the cost of insured services received in the hospital, on presentation to the commissioner of a detailed receipt from the hospital for payments made to the hospital by him; or

(b) make payment directly to the hospital for the insured services received by the insured person.

(2) No payment shall be made under subsection (1) unless

(a) the care and treatment

(i) was required because of accident or sudden attack of illness; or

(ii) could not be adequately supplied in a hospital in Manitoba and the commissioner signifies his approval, in writing; or

(iii) was supplied to a person named in an out of province certificate or in a dependant's out of province certificate.

(b) the hospital that supplied the care and treatment is one that is licensed or approved as a hospital by the governmental hospital licensing authority in the jurisdiction of which the hospital is situate or by the Government of Canada.

(c) the commissioner receives from the hospital outside Manitoba that provided the care and treatment to the insured person a certificate that shows

(i) that the patient was admitted, with the date of admission;

(ii) the diagnosis of the condition for which the patient was admitted;

(iii) the date of discharge or death of the patient;

(iv) the nature of any complication, complications, or sequelae, if any, that would explain a longer than average stay in hospital for a person with the disease or condition from which the patient was suffering;

(v) the nature of any special treatment procedures or surgery that were performed on the patient;

(vi) the discharge diagnosis or cause of death, as the case may be; and

(vii) such other information as may be required and requested by the commissioner.

(d) where the hospital care and treatment continued beyond a period of 30 days the commissioner was notified of that fact in writing not later than the 33rd day.

(3) The commissioner shall not pay an amount for insured services rendered to an insured person by a hospital outside Manitoba that, in the opinion of the commissioner, is greater than the amount which such services would have cost had they been provided in Manitoba in a hospital of approximately equivalent size and with similar facilities, unless the services were supplied by a hospital in a participating province, in which case the amount paid may be determined according to the rates established by the provincial authority in that participating province.

(4) The accommodation and services received shall not constitute, in the opinion of the commissioner, a custodial type of care provided in a home for the aged, an infirmary or other institution of a similar character, or treatment in a mental, psychiatric or tuberculosis hospital.

(5) Where the amount charged for insured services rendered by a hospital outside Manitoba is greater than the amount that, in the opinion of the commissioner, such services would have cost had they been provided in Manitoba in a hospital of approximately equivalent size and with similar facilities, the insured person is personally responsible to the hospital for the payment of that additional amount.

45. Where the commissioner, after such inquiries and on such evidence as is satisfactory to him, is satisfied that an insured person receiving insured services in a hospital outside Manitoba, no longer requires those insured services, he shall notify the insured person and the hospital of that fact; and, in respect of the illness under review, the commissioner shall not make any payments to the hospital or to the patient for insured services received after such notification.

46. The commissioner may enter into an agreement with the hospital insurance authority of a participating province to pay the appropriate rate established by that authority for insured services supplied any insured person who, because of an accident or a sudden attack of illness, requires emergency care and treatment in one of the hospitals in the participating province approved under the hospital insurance plan of that province to render care and treatment.

47. The commissioner may enter into an agreement with any hospital situated outside Manitoba to pay for insured services provided by the hospital to an insured person.

48. Subsection (4) of section 7 of the Act applies to an insured person who is a patient in a hospital outside Manitoba.

HOSPITAL BUDGETS AND COMMITTEE

49. (1) The costs not included in an agreement but that must be shown separately in a hospital budget to which reference is made in section 21 of the Act are:

(a) Interest on that part of the capital debt of the hospital that has been approved by the minister.

(b) Depreciation on the buildings and fixed equipment computed as the commissioner may approve.

(c) Such other costs as the minister may approve.

(2) Every hospital licensed under The Hospitals Act shall submit its budget to the commissioner

(a) in respect of the period from July 1st to December 31st, 1958, on or before June 15th, 1958; and

(b) in respect of the year 1959 and subsequent years, on or before October 15th of the preceding year.

50. The Hospital Budget Committee shall consist of:

(a) the commissioner;

(b) the Deputy Minister of Health;

(c) the Director of Hospital Standards under The Hospitals Act;

(d) the Director of Hospital Budgets and Accounting under the Act; and

(e) the assistant to the commissioner;

of whom the two mentioned in clauses (a) and (b) shall be the chairman and vice-chairman respectively, in the order listed.

HOSPITAL RETURNS BOOKS AND RECORDS

51. Every hospital licensed under The Hospitals Act and every other hospital in Manitoba that is entitled under the Act to receive payments from the commissioner in respect of insured services provided in that hospital shall forward to the commissioner.

(a) except in the case of a member of the regular forces of the Canadian Forces or of the Royal Canadian Mounted Police Force, within 48 hours after admission of an in-patient who is a resident but not an insured person, a report in such form, and containing such information, as the commissioner may prescribe;

(b) within 48 hours after

(i) the admission of an in-patient; or

(ii) the treatment of an out-patient;

who receives insured services that are required by reason of injuries or disabilities inflicted on or caused to him by, or by reason of the fault or negligence of another person, a report in such form and containing such information as the commissioner may prescribe;

(c) within 96 hours after an in-patient is discharged from hospital or dies in a hospital, a notification of the discharge or death, together with a report showing the diagnosis of the patient's condition at the time of discharge, or the cause or probable cause of death, as the case may be, and the report shall be in such form and contain such other information as the commissioner may prescribe; and

(d) every 30 days, in respect of each in-patient who is hospitalized for 30 days or more and is an insured person, a long stay report in such form, and containing such information, as the commissioner may prescribe.

52. Every hospital licensed under The Hospitals Act shall keep up to date such books and records as will comply with the established and recognized accounting procedures and practices for hospitals, and such particular books and records as may be specifically required by the commissioner, in writing.

MISCELLANEOUS

53. All unorganized areas and Federal penitentiaries are designated areas within the meaning of subsection (4) of section 8 of the Act.

54. (1) Subject to subsection (2), the remuneration payable to an agent other than an employer is 3 per centum of the premiums remitted to the commissioner by that agent, but an agent shall not be paid less than $25.00 per annum.

(2) Subsection (1) does not apply to an agent who is also an employer in respect of premiums remitted by him for himself or for any of his employees.

55. In any hospital licensed under The Hospitals Act, the proportion of standard ward beds to total beds shall not be less than 50 per centum unless the commissioner otherwise orders.

56. The maximum charges that may be made by a hospital directly to an insured person for hospital accommodation are

(a) in respect of semi-private wards, $2.50 per day; and

(b) in respect of private wards, such amount as the commissioner deems reasonable.

57. (1) A person who is not a resident shall not register or pay a premium under the Act or this regulation.

(2) The registration of, or the payment of a premium by or on behalf of, any person who is not a resident does not entitle that person to be an insured person or to receive insured services.

58. An adoption de facto to which reference is made in clause (e) of subsection (1) of section 2 of the Act, includes the case of a person under the age of nineteen years and unmarried in respect of whom a family head stands in the place of a parent and who is mainly supported by that family head.

59. The father of a person to whom sub-clause (i) of clause (w) of subsection (1) of section 2 of the Act applies is a recipient of public assistance.

60. Where for the purposes of the Act or this regulation any question arises as to whether a person is a resident of Manitoba, the minister on such evidence and after hearing such representations as he may consider advisable shall determine that issue and his determination shall be final and binding in respect of that person.

61. Where any question arises as to whether a person would be entitled to assistance under The Old Age Assistance Act as referred to in sub-clause (vi) of clause (w) of subsection (1) of section 2 of the Act, the issue shall be determined by The Old Age Assistance and Blind Persons' Allowance Board established under The Health and Public Welfare Act and the decision of that Board shall be final and binding.

62. A person who otherwise qualifies as a dependant does not lose that status solely because he is in receipt of an income of $1,000.00 per year or less.

63. On or before the 1st day of March in each year the commissioner shall report to the minister in respect of the operation of The Manitoba Hospital Services Plan during the preceding year.

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